Complete Summary

GUIDELINE TITLE

Identification and ambulatory care of HIV-exposed and -infected adolescents.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents . New York (NY): New York State Department of Health; 2003. 21 p. [22 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Acquired immune deficiency syndrome (AIDS)

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To provide guidelines for the identification and ambulatory care of human immunodeficiency virus (HIV)-exposed and -infected adolescents

TARGET POPULATION

Human immunodeficiency virus (HIV) exposed and HIV infected adolescents and young adults between the ages of 13 and 24 years of age

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Identification of human immunodeficiency virus (HIV)-infected adolescents through counseling, HIV testing, and risk assessment
2. Referrals to mental health services
3. Baseline medical history including
    - Reason for referral
    - Reason for choosing to have an HIV test or length of time that the adolescent has been aware of his/her HIV status and has been in care
    - Assessment of current HIV-related symptoms
    - Past medical history
    - Sources of past medical care
    - Review of systems (including menstrual history)
    - Growth and development
    - Social history
    - Sexual history and risk reduction education
    - Tobacco use history and risk reduction education

- Substance use history and risk reduction education
- Dietary history
- Information about New York State Partner Notification Law

4. Baseline physical examination, including
    - Vital signs
    - Dermatologic examination
    - Lymph node examination
    - Funduscopic examination
    - Oral examination
    - Chest examination
    - Abdominal examination
    - Genital examination
    - Rectal examination
    - Neurologic examination
    - Mental status examination
5. Baseline laboratory evaluation, including
    - HIV antibody testing
    - Immunologic assessment (helper lymphocyte [CD4] count)
    - Virologic assessment
        - Quantitative HIV-ribonucleic acid (RNA) testing for viral load
        - Genotypic resistance testing (when clinically indicated)
    - Tuberculosis evaluation
        - Purified protein derivative (PPD) skin test (5TU)
        - Chest x-ray if PPD is positive
    - Additional baseline tests
        - Urinalysis
        - Complete blood count (CBC) including differential
        - Serum liver enzymes, creatinine, blood urea nitrogen (BUN), total protein, and albumin
        - Toxoplasma gondii antibody screening
        - Hepatitis A, B, and C antibody screening
        - Varicella antibody screening
        - Serum creatine phosphokinase (CPK), amylase and lipase, cholesterol levels, and triglycerides (when clinically indicated)
    - Tests for sexually active adolescents
        - Cervical Papanicolaou (Pap) smear
        - Culture or deoxyribonucleic acid (DNA) amplification test for gonorrhea
        - Rapid plasma reagent (RPR) test or Venereal Disease Research Laboratory (VDRL) test for syphilis with verification of positive test by confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test or microhemagglutination assay for Treponema pallidum (MHA-TP)
        - Immunofluorescence or DNA amplification test for chlamydia
        - Wet preparation for trichomonads, clue cells, and leukocytes
        - Herpes simplex virus cultures as indicated
        - Potassium hydroxide (KOH) preparation for whiff test and Candida hyphae
        - Pregnancy test as indicated
6. Immunizations (when clinically indicated), including Measles-mumps-rubella (MMR), hepatitis B, tetanus booster (Td), pneumococcal vaccine, influenza vaccine, hepatitis A vaccine, varicella vaccine, meningococcal vaccine

7. Ongoing evaluation, including comprehensive annual examination, routine visits every 3 months, routine laboratory evaluations, and counseling
8. Ongoing psychosocial assessments (e.g., housing, education, family, sexual partners, safe sex practices, drug use, parenting skills)

Treatment/Management

1. Prophylactic, therapeutic, and antiretroviral (ARV) treatments for HIV-related infections and illnesses
2. Assessment of patient's readiness to start and ability to follow regimen, clinical factors (e.g., CD4 count, viral load) and non-clinical factors (e.g., living environment, mental health, pregnancy) when selecting medication
3. Regimens with a low number of pills, low frequency of administration, and combination pills such as combined zidovudine/lamivudine (Combivir) and lopinavir/ritonavir (LPV/r) (Kaletra)
4. Combined zidovudine/lamivudine (Combivir) in combination with non-nucleoside reverse transcriptase inhibitors (NNRTIs) (e.g., nevirapine* or efavirenz)
5. Education about ARV medications
6. Adherence monitoring
7. Coordinator of multidisciplinary care
8. Referrals to drug treatment programs, community-based organizations, counseling and support programs

*Note from the National Guideline Clearinghouse: On January 19, 2005, the U.S. Food and Drug Administration (FDA) issued a public health advisory about recent safety-related changes to the nevirapine (Viramune®) label and about appropriate use of HIV triple combination therapy containing nevirapine. The Indications and Usage section now recommends against starting nevirapine treatment in women with CD4+cell counts greater than 250 cells/mm^3 unless benefits clearly outweigh risks. This recommendation is based on a higher observed risk of serious liver toxicity in patients with higher CD4 cell counts prior to initiation of therapy. See the FDA Web site for more information.

Considerations for Special Populations

1. Referrals to specialized clinical, mental health, and substance abuse treatment services
2. Referrals to case managers and social workers

MAJOR OUTCOMES CONSIDERED

- Risk and incidence of human immunodeficiency virus (HIV) infection in adolescents
- Acquired immunodeficiency syndrome (AIDS) survival rates

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person three to four times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one

member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

<u>Identification of Human Immunodeficiency Virus (HIV) Infected Adolescents</u>

- Clinicians should provide HIV counseling for all adolescents and recommend HIV testing to sexually active adolescents when they present for care.
- Clinicians should obtain a sexual risk history at the annual physical examination.
- Clinicians should assess risk issues, including sexual activity and substance use, as well as home environment, history of violence, involvement in foster care, family history, and school, for those in care or undergoing HIV pre- and post-test counseling. Questions regarding physical and sexual abuse, sexual assault, and suicidal ideation, gestures, or attempts should be asked.
- An adolescent who exhibits symptoms of major depression or symptoms of other severe psychiatric disorders during pre-test counseling should be referred immediately for mental health services. If there is an acute risk of suicidal behavior, HIV testing should be deferred until the risk has been appropriately addressed.
- Clinicians should be knowledgeable about New York State laws pertaining to adolescent consent and confidentiality and should educate their patients about these laws. For more information on a minor's rights regarding consent and confidentiality, refer to Appendix A in the original guideline document.
- Clinicians who care for HIV-infected youths should develop referral agreements with testing sites where youths are initially diagnosed with HIV disease.
- The clinician should identify a supportive adult to whom the adolescent can safely disclose HIV-related information.

Baseline Medical History of HIV Infected Adolescents

- During baseline visits, clinicians should obtain a complete medical history (refer to Table below entitled "Elements of a Baseline History for HIV-Infected Adolescents").
- The sexual history of a sexually active adolescent patient should focus on risk assessment, including the number of recent sexual partners, whether the patient currently has any sexual partners, and, if so, whether or not there are multiple partners or one stable partner. Clinicians should offer assistance with partner notification if needed.
- Youths should be informed of the New York State Partner Notification Law as it pertains to HIV-infected individuals during HIV pre-test counseling and prior to obtaining consent for testing (see Appendix B in the original guideline document). Providers should also offer assistance in disclosing HIV status to partners.

Table: Elements of a Baseline History for HIV-Infected Adolescents

- Reason for referral
- Reason for choosing to have an HIV test or length of time that the adolescent has been aware of his/her HIV status and has been in care
- Assessment of current HIV-related symptoms. The clinician should also identify symptoms that might suggest acute HIV infection.
- Past medical history, including major and childhood illnesses, medications, psychiatric history, hospitalizations, allergies, immunizations, and history of tuberculosis (TB) or TB exposure
- Sources of past medical care
- Review of systems, including menstrual history
- Growth and development
- Social history
    - Living situation
    - Sources of emotional and social support, including social service agencies and counselors and, if relevant, persons who know of HIV status; identification of a supportive adult with whom adolescent can disclose and discuss HIV-related information
    - Family medical and psychological history, including access to health care and custody arrangements
    - Peer relationships
    - Education, learning disabilities
    - Employment status
    - History of violence
    - Legal status (emancipated*)
    - Legal problems
    - Citizenship, immigration status
- Sexual history
    - Age at initiation of sexual intercourse
    - Pattern of sexual relationships, number and gender(s) of sexual partners
    - Sexual practices (oral, anal, vaginal)
    - Disclosure to partner(s) of known HIV status**
    - Contraceptive history and current practices, specifying frequency and condom use

    - Self-assessment of safer sex practices
    - Pregnancy history
    - Sexual abuse (personal or family)
    - Sexually transmitted diseases (STDs)
- Tobacco use history
- Substance use history, history of use and abuse of alcohol, marijuana (THC), cocaine, crack, methamphetamines, ecstasy, opiates, steroids, hormones, and other substances, including identification of type, route, specifying injection history--amount, frequency, and treatment history
- Dietary history

*In New York State, examples of when a minor might be considered emancipated are as follow: if he/she is married, he/she is in the armed forces, he/she has established a home and is financially independent.

**If HIV status has not yet been disclosed to partner(s), the clinician should offer assistance with partner disclosure.

Baseline Physical Examination for HIV Infected Adolescents

- During baseline visits, the clinician should perform a full physical examination with emphasis on HIV-associated manifestations (refer to Table below entitled "HIV-Specific Elements of a Comprehensive Physical Examination for HIV-Infected Adolescents"). The examination should include an external genital, breast, and axilla examination using the Tanner rating scale for sexual maturity and perianal inspection of male and female patients. A pelvic examination including sexually transmitted diseases (STD) screening is indicated for female patients who have had sexual intercourse, ask for a pelvic examination, or have an unexplained gynecologic problem.
- A mental status examination should be performed, which includes assessment of general mood, depression, suicidal ideation and attempts, and an abbreviated examination for cognitive function. (See the New York State Department of Health AIDS Institute publication Mental Health Care for People With HIV Infection for further guidance.)

Table: HIV-Specific Elements of a Comprehensive Physical Examination for HIV-Infected Adolescents

- Vital signs, including assessment of pain
- Dermatologic examination
    - Examine for all skin conditions, including the following:
        - Seborrheic dermatitis
        - Psoriasis
        - Maceration of the gluteal cleft
        - Kaposi's sarcoma
        - Molluscum contagiosum
        - Onychomycosis
        - Diffuse folliculitis with pruritus
- Lymph node examination
    - Examine for the following:
        - Supraclavicular and axillary nodes
        - Clusters of large nodes
        - Asymmetric nodes

        - Sudden increase in size or firmness of nodes
- Funduscopic examination
    - Examine for the following:
        - Cytomegalovirus retinitis
        - HIV-related retinopathy
- Oral examination
    - Examine for the following:
        - Oral candidiasis (thrush)
        - Hairy leukoplakia
        - Kaposi's sarcoma
        - Gingival disease
        - Aphthous ulcers
        - Periodontal disease
        - Oral herpes simplex
- Chest examination
    - Examine for the following:
        - Heart rhythm
        - Lung fields for wheezes, rhonchi, rales, or dullness
        - Heart murmur, click, or rub
- Abdominal examination
    - Examine for the following:
        - Hepatosplenomegaly
        - Multiple lipomata in the subcutaneous fat
        - Increased visceral fat
- Genital examination
    - Examine for the following in both males and females:
        - Venereal warts (HPV)
        - Classic and atypical herpes simplex virus (HSV)
        - Ulcerative genital disease
    - Perform a careful pelvic examination and Pap smear in females.
    - Assess sexual maturity according to Tanner scale.
- Rectal examination
    - Rectal examination for visible anal lesions or evidence of skin abnormality around the anus
        - Consider obtaining an anal Papanicolaou (Pap) smear in men and women with visible anal lesions or evidence of skin abnormality around the anus.
- Neurologic examination
    - Examine for sensory and motor abnormalities, cerebellar function.
    - Mental status examination, including cognitive assessment, orientation, registration and recall, attention/calculation, and language (naming, repetition, command)
    - Screen for depression and anxiety.

<u>Baseline Laboratory Evaluation</u>

- When performing laboratory tests for HIV-infected adolescents, clinicians should follow guidelines for adults.
- Clinicians should perform baseline laboratory tests for HIV-infected adolescents which include immunologic and virologic assessment, evaluation for tuberculosis, STD screening, hepatitis antibody panels, and other baseline

tests (refer to Table below entitled "Baseline Laboratory Tests for HIV-Infected Adolescents").

Table: Baseline Laboratory Tests for HIV-Infected Adolescents

- HIV antibody test

  Retesting should be provided if written documentation of the positive test result or detectable viral load is not available, if an initial positive test has not yet been confirmed, or if the patient requests it.

- Immunologic assessment

  CD4 lymphocyte count, both absolute count and percentage; to produce reliable results, the same testing laboratory should be used consistently.

- Virologic assessment
  - Quantitative HIV-ribonucleic acid (RNA) testing for viral load assessment (performed twice using the same testing method)
  - Genotypic resistance testing should be performed 1) prior to initiating treatment in anti-retroviral (ARV) therapy-naïve patients to determine whether they were infected with drug-resistant virus, and 2) in patients experiencing virologic failure or incomplete viral suppression while receiving ARV therapy.
- Tuberculosis evaluation
  - Purified protein derivative (PPD) skin test, 5TU (not necessary for a patient with a known positive or previously documented tuberculosis [TB])
  - Chest x-ray if PPD is positive
- Additional baseline tests
  - Urinalysis
  - Complete blood count (CBC), including differential
  - Serum liver enzymes, creatinine, blood urea nitrogen (BUN), total protein, and albumin
  - Toxoplasma gondii antibody screening
  - Hepatitis A antibody screening for men who have sex with men, injecting drug users, those from an endemic area, and those with liver disease
  - Hepatitis B antibody screening
  - Hepatitis C antibody screening
  - Varicella antibody screening
  - Serum creatine phosphokinase (CPK), amylase and lipase, cholesterol levels, and triglycerides (if not initiating ARV treatment, these tests can be deferred)
- Tests for sexually active adolescents*
  - Cervical Papanicolaou (Pap) smear**
  - Culture or deoxyribonucleic acid (DNA) amplification test for gonorrhea (depending on the sexual behaviors reported or suspected, oral and anal cultures may be indicated, as well as cervical or urethral cultures)
  - Rapid plasma reagin (RPR) or Venereal Disease Research Laboratory test (VDRL) for syphilis with verification of positive test by confirmatory fluorescent treponemal antibody absorption test (FTA-

Abs) or microhemagglutination assay-Treponema pallidum assay (MHA-TP)
- Immunofluorescence or DNA amplification test for chlamydia
- Wet preparation for trichomonads, clue cells, and leukocytes
- Herpes simplex virus cultures as indicated
- Potassium hydroxide (KOH) preparation for "whiff" test and Candida hyphae
- Pregnancy test as indicated

*STD screening is equally important for both male and female adolescents.

**The NYSDOH AI recommends that Pap smears be performed at least annually in HIV-infected women as long as the results are normal. Women with abnormal Pap smears should receive more frequent follow-up, with repeated Pap smears every 3 to 6 months until there have been two successive normal Pap smears. The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap smear, a repeat examination at 6 months, and then annually thereafter. The American College of Obstetrics and Gynecology (ACOG) recommends Pap smear every 6 months for HIV-infected women.

Treatment With Highly Active Antiretroviral Therapy

- The clinician should educate the adolescent about ARV therapy and seek to make the adolescent a "partner" in the decision-making process.
- The clinician should assess a youth's readiness to start and ability to adhere to treatment prior to dispensing any medications.
- Decisions pertaining to ARV therapy should be weighed against clinical factors (e.g., CD4 count, viral load, and HIV-related symptoms) as well as non-clinical factors (e.g., living environment, mental health, HIV disclosure to others, pregnancy, and health beliefs).
- Adolescents beginning ARV therapy should be seen at least one month after starting therapy to monitor adherence, toxicity, and proper dosing.

Treatment Adherence

- Prior to offering medications, the clinician should educate the adolescent about ARV medications and how they work.
- Once an adolescent has initiated ARV therapy, the clinician should assess treatment adherence at routine visits.
- Clinicians should become familiar with the availability of treatment adherence services in their area and should use them when appropriate.

Ongoing Medical Evaluation

- Adolescents should receive a comprehensive annual examination including a complete physical examination.
- Adolescents should be seen for routine visits at least every three months. An interim history of HIV-related symptoms, ongoing risk behaviors, and psychosocial issues should be obtained during each routine visit.
- Laboratory evaluations should occur on a routine basis (refer to Table below entitled "Ongoing Laboratory Tests").
- The clinician should regularly discuss birth control, safe sex, and partner disclosure with patients, and should offer to assist with partner disclosure.

- When ARV therapy is indicated but the youth chooses not to accept it, each routine visit should be viewed as an opportunity to review treatment options.

Table: Ongoing Laboratory Tests

- Immunologic assessment (every 3 to 4 months)

  CD4 lymphocyte count and percentage; to produce reliable results, the same testing laboratory should be used

- Virologic assessment (every 3 months)

  Quantitative HIV-RNA testing for viral load assessment (this should be performed more frequently if clinically indicated); the same testing method should be used. HIV genotypic/phenotypic resistance testing is indicated when treatment failure is suspected.

- Tuberculosis evaluation (annually)
  - PPD skin test
  - Chest x-ray for patients known to have a history of TB or known to be PPD positive
- Tests for sexually active adolescents (every 6 months or if STD-related symptoms are present)
  - Pap smear*; colposcopy, if dysplasia is noted
  - Culture or DNA amplification test for gonorrhea
  - Immunofluorescence, or DNA amplification test for Chlamydia
  - RPR or VDRL screening test for syphilis (at least annually)
  - Wet preparation for trichomonads, clue cells, and leukocytes
  - KOH preparation for "whiff" test and Candida hyphae
  - Pregnancy test, as indicated
- Complete blood count (every 3 months)
- Serum creatinine, BUN, total protein, albumin (every 3 months)
- Additional ongoing tests for patients receiving ARV therapy
  - Serum CPK, serum liver enzymes, amylase, lipase, cholesterol levels, triglycerides

*The NYSDOH AI recommends that Pap smears be performed at least annually in HIV-infected women as long as the results are normal. Women with abnormal Pap smears should receive more frequent follow-up, with repeated Pap smears every 3 to 6 months until there have been two successive normal Pap smears. The Centers for Disease Control and Prevention (CDC) and the Agency for Health Care Policy recommend that HIV-infected women receive a gynecological evaluation with pelvic examination and Pap smear, a repeat examination at 6 months, and then annually thereafter. The American College of Obstetrics and Gynecology (ACOG) recommends Pap smear every 6 months for HIV-infected women.

Ongoing Psychosocial Intervention

- The clinician should play a central role in coordinating a multidisciplinary care approach for the HIV-infected adolescent.
- Ongoing assessments of the adolescent's housing situation, education, family, sexual partners, safe sex practices, drug use (if applicable), and the adolescent's parenting skills (if applicable) should be integrated into the adolescent's medical care.

- When making referrals to drug treatment programs, community-based organizations, and counseling and support programs, the clinician should try to identify agencies with adolescent-focused services.
- Clinicians should be familiar with New York State laws pertaining to an adolescent's right to consent for certain forms of health care.

Special Populations

- Clinicians working with HIV-infected youths should develop skills to work with adolescents with special needs, including perinatally infected adolescents, gay adolescents, transgendered adolescents, pregnant adolescents, substance-using adolescents, and homeless adolescents.

Perinatally Infected Adolescents

- Perinatally infected adolescents should be assessed for HIV transmission risk behaviors regardless of their developmental stage. The interventions employed for risk reduction should be individualized for the adolescent's developmental stage.
- Perinatally infected adolescents have the capacity to understand the meaning of an HIV diagnosis and should be informed of their diagnosis if disclosure has not already occurred during childhood.
- The clinician should begin to shift from discussing treatment with the family/caregivers to directly discussing treatment with the perinatally infected adolescent in an age-appropriate manner.
- If an adolescent makes an educated informed decision to discontinue treatment the clinician should respect that decision.
- Sexuality, contraception, substance use, gynecology, and adolescent treatment adherence patterns, should be discussed.
- Pediatricians caring for perinatally infected adolescents should provide or refer for certain clinical services, including gynecologic examinations, contraception/family planning, STD screening, substance use assessment and treatment, and adolescent-focused mental health services.

Gay Adolescents

- Clinicians should perform a comprehensive psychosocial assessment of gay adolescents and should facilitate referrals for mental health care when indicated.
- The clinician should be part of a support network for a gay adolescent who is more likely to experience feelings of alienation, rejection, and ostracism as compared to his/her same-age peers.
- The clinician should be able to counsel the gay adolescent about issues of disclosure of his/her sexuality as well as his/her HIV status. If necessary, the clinician should facilitate safe disclosure to parents and other family members.
- Clinicians should be able to counsel gay youths on risk reduction in a manner that is non-judgmental and is consistent with the youth's sexuality.
- Clinicians should screen gay youths for sexually transmitted diseases yearly and more often if necessary.
- Clinicians should be able to detect the warning signs of adolescent suicide by directly asking questions about whether patients are feeling depressed or

isolated, whether they have supportive individuals to whom they can turn, and whether they have had any recent suicidal ideation or gestures.

Transgendered Adolescents

- Clinicians working with transgendered youths should be capable of addressing the specific issues associated with this population, such as mental health, gender identity, hormonal therapy, and sexuality needs.
- Clinicians should obtain a gender identity assessment and inquire about hormone use in transgendered patients.

Pregnant Adolescents And Adolescent Parents

- Clinicians should discuss options with patients who are making decisions about carrying pregnancy to term or terminating pregnancy.
- Clinicians should advise pregnant adolescents who choose to carry pregnancy to term about the benefits of ARV therapy in reducing perinatal transmission.
- Clinicians should have referral agreements with obstetrical services that can provide care to HIV-infected women during pregnancy; however, the clinician may want to continue to be the primary care provider for the adolescent during the pregnancy (refer to the NYSDOH AIDS Institute's Management of HIV-Infected Pregnant Women Including Prevention of Perinatal HIV Transmission for further guidance).

Adolescent Substance Users

- Clinicians should be familiar with programs that provide drug detoxification and maintenance as therapeutic modalities.
- Clinicians should be able to detect alcohol and marijuana use and should be able to provide counseling as well as referral for treatment.
- Clinicians should be familiar with both harm reduction-based and abstinence-based drug treatment programs for the purposes of referral.
- Clinicians should be aware of drug interactions between HIV-related medications and illicit drugs.

Homeless Adolescents

- Clinicians should work closely with case managers and social workers to help homeless youths find appropriate housing.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Potential Benefits

- Appropriate identification and ambulatory care of human immunodeficiency-exposed and -infected adolescents

Specific Potential Benefits

- The purpose of the sexual history and risk behavior assessment is to enable the clinician to provide appropriate risk reduction education, including a discussion of safer sex practices. The intention of this counseling is to prevent further HIV transmission as well as the possible acquisition of resistant HIV.

POTENTIAL HARMS

Side effects of antiretroviral (ARV) therapy

CONTRAINDICATIONS

CONTRAINDICATIONS

Efavirenz is contraindicated in pregnant women.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (HIV clinical practice guidelines, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience
- Define target audience (providers, consumers, support service providers).

        - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
    - Define implementation methods.
        - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
    - Determine appropriate implementation processes.
        - What steps need to be taken to make these activities happen?
        - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
        - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
        - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
    - Monitor progress.
        - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
    - Evaluate.
        - Did the processes and strategies work?
        - Were the guidelines implemented?
        - What could be improved in future endeavors?

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Identification and ambulatory care of HIV-exposed and -infected adolescents . New York (NY): New York State Department of Health; 2003. 21 p. [22 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Committee for the Care of Children and Adolescents with HIV Infection.

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Identification and ambulatory care of HIV-exposed and - infected adolescents. Tables and recommendations. New York (NY): New York State Department of Health; 2003 Nov. 17 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

PATIENT RESOURCES

None available

NGC STATUS

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